Engaging Stakeholder Communities as Body Image Intervention Partners:

The Body Project as a Case Example

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Abstract

Despite recent advances in developing evidence-based psychological interventions, substantial changes are needed in the current delivery system of interventions in order to impact mental health on a global scale (Kazdin & Blase, 2011). Prevention offers one avenue for reaching large populations because prevention interventions often are amenable to scaling-up strategies, such as task-shifting to lay providers, which further facilitate partnerships with community stakeholders. This paper discusses the dissemination and implementation of the *Body Project*, an evidence-based body image prevention program, across 6 diverse stakeholder partnerships that span academic, non-profit and business sectors at national and international levels. The paper details key elements of the *Body Project* that facilitated partnership development, dissemination and implementation, including use of community-based participatory research methods and a blended train-the-trainer and task-shifting approach. We observed consistent themes across partnerships, including: sharing decision making with community partners, engaging of leaders within the community as gatekeepers, emphasizing strengths of community partners, making efforts to work within the community's structure, optimizing non-traditional and/or private financial resources, placing value on cost-effectiveness and sustainability, marketing the program, and supporting flexibility and creativity in developing strategies for evolution within the community and in research. Ideally, lessons learned with the *Body Project* can be generalized to implementation of other body image and eating disorder prevention programs.

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In a seminal 2011 paper, Kazdin and Blase argued that psychotherapy needs to be

"rebooted" if the field ever hopes to address the global burden of mental illness. They noted that

expert-led psychotherapy, the dominant form of mental health intervention, is too expensive to

address the needs of everyone with mental illness, even if every therapist worldwide only

delivered empirically supported interventions. They proposed several solutions including:

increasing focus on prevention, addressing the continuum of care, using task-sharing/shifting

with layperson providers, and increasing cross-disciplinary partnerships.

As Kazdin and Blase (2011) note, prevention already leads treatment in addressing their

concerns. For instance, prevention more explicitly addresses a continuum of care via

classification of interventions as universal (i.e., to an entire population), selective (i.e., to those at

risk), and targeted/indicated (i.e., to those expressing early symptoms: Mrazek & Haggerty,

1994). Yet, both the eating disorders prevention and body image intervention fields, which often

target similar psychosocial influences, often fall prey to various traps described by Kazdin and

Blase. Specifically, most of our interventions use an expert-led approach targeting a limited

range of high-risk individuals, typically young women with pre-existing body image concerns.

The *Body Project* (*TBP*) is a body image intervention with extensive empirical support

(see below). Although much of the research supporting *TBP* (e.g., Stice, Rohde, Butryn, Shaw, &

Marti, 2015; Stice, Rohde, Shaw, & Gau, 2011; Stice, Shaw, Burton, & Wade, 2006) is

selective/indicated, *TBP* also has been implemented with lower-risk populations. For instance,

some studies and dissemination efforts targeted mixed-risk groups (e.g., those with low *and*

elevated body image concerns: Becker, Bull, Schaumberg, Cauble, & Franco, 2008; Becker et al., 2010); adolescent girls in western and non-western countries (http://www.free-being-me.com/); and males (Brown & Keel; 2015; Jankowski, Diedrichs, Fawkner, Gough, & Halliwell, submitted; Kilpela et al., submitted). Further, *TBP* community has embraced other suggestions proposed by Kazdin and Blase, including task-shifting to lay providers and utilizing community participatory research (CPR) methodology to foster effective partnerships with stakeholders.

Herein we aim to describe the diverse stakeholder partnerships that have advanced the research and dissemination/implementation of *TBP* worldwide so as to help other intervention developers establish effective partnerships. We first provide a background on CPR. We then briefly review the empirical evidence supporting TBP because all current partners report finding the strong evidence base, as well as program acceptability, critically important; we also describe our current leadership structure. Next, we discuss key partnerships that have played a critical role in the study and implementation of *TBP* and highlight lessons learned from each partnership. <u>Although we have tried to avoid too much redundancy in lessons learned across partnerships, common themes (e.g., creating mutual benefit and return on investment) do emerge.</u>

As noted above, Kazdin and Blase argue that cross-disciplinary partnerships are essential to reducing the burden of mental illness. Our experiences suggest that such partnerships bring new ideas to the table, elucidate novel avenues for implementation, and create opportunities for changing behaviors at a macro/community level. We hope this paper facilitates dissemination and implementation of other empirically supported prevention programs.

1.1   Body Project Empirical Support and Leadership Structure

TBP is a cognitive dissonance-based intervention in which young women voluntarily critique the thin-ideal standard of female beauty via verbal, written, and behavioral exercises. This theoretically creates the uncomfortable psychological state of cognitive dissonance, which prompts participants to reduce thin-ideal internalization because people are motivated to maintain consistency between attitudes and behaviors. Reduced thin-ideal internalization putatively decreases body dissatisfaction, ED symptoms, and ED onset. *TBP* has produced larger reductions in thin-ideal internalization, body dissatisfaction, dietary restraint, and ED symptoms than assessment-only control conditions and alternative interventions in multiple efficacy trials with a range of follow-up times out to 3-years (Becker, Smith, & Ciao, 2005; Green, Scott, Diyankova, Gasser, & Pederson, 2005; Halliwell & Diedrichs, 2014; Matusek et al., 2004; Mitchell, Mazzeo, Rausch, & Cooke, 2007; Stice et al., 2003, 2006, 2008). *TBP* also yielded a 60% reduction in eating disorder onset relative to assessment-only at 3-year follow-up in the largest efficacy trial (Stice et al., 2008). Furthermore, effectiveness research indicates that *TBP* can be successfully delivered by undergraduate peer-leaders (Becker et al., 2006; 2008; 2010).

Research supports the theory underpinning *TBP*. Reductions in thin-ideal internalization mediated the effects of *TBP* on symptom reductions in Seidel et al. (2009) and Stice et al. (2007). *TBP* also eliminated negative effects of exposure to thin models on body dissatisfaction (Halliwell & Diedrichs, 2014). Lastly, an fMRI study found that *TBP* participants showed a greater pre-post reduction in reward region (caudate) neural responsivity to thin models and attentional (anterior cingulate) response to thin-ideal statements than controls (Stice et al., 2013).

TBP is currently implemented worldwide and is supported by a global community of researchers, clinicians, stakeholder organizations, and body image activists. We maintain a loose leadership structure. More specifically, anyone can study and implement *TBP* simply by buying

the official manual or by downloading free scripts from www.bodyprojectsupport.org. Despite

this, we strongly recommend (but don't require) that new members to our community receive

training to maximize program effectiveness, particularly when working with lay providers (e.g.,

peer leaders; teachers); we also request (but don't require) that people keep Dr.'s Becker and

Stice informed as to their work with *TBP*. There is no formal mechanism for people to do this,

however; rather stakeholders stay in touch via email and at conferences. In 2012, we established

the Body Project Collaborative (BPC) to create training infrastructure. The BPC consists of

highly experienced *TBP* trainers and researchers. To simplify terminology for the rest of the

paper, we will describe current partnerships as occurring between the BPC and other

organizations.

1.2   Community Participatory Research (CPR)

In contrast to traditional research, in which researchers develop an idea and then recruit

participants, CPR engages community stakeholders in sharing decision making and power

(Israel, Eng, Shculz, & Parker, 2005). CPR seeks to improve problem solving and increase

knowledge by integrating multiple perspectives (Israel et al., 2005; Shoultz et al., 2006). We use

the term CPR to describe how we approach partnerships regardless of whether or not we expect

them to be focused primarily on intervention implementation, research, or both. Israel et al.

(2005) describe nine major facets of CPR. These include: acknowledging that communities

consist of individual members who have connection to the community; building on community

strengths; developing equitable and collaborative partnerships; advancing capacity building and

co-learning for all; balancing joint demands of creating new knowledge with providing useful

intervention; recognizing that health problems are currently troublesome for communities;

engaging in a collaborative, cyclical and iterative process; sharing results in a way that respects

stakeholders and provides useful information; and developing long term commitment to the project, community and sustainability

1.3 Partnerships

1.3.1 Universities

Universities represent one of the largest cohorts of *TBP* implementers. In this section we describe several university-focused partnerships to illustrate how a variety of collaborations enhance *TBP* implementation.

1.3.1.1 Sororities

Our partnerships with sororities highlight the critical importance of CPR methods and the importance of creating sustainable strategies for implementation. *TBP* global community is the culmination of over 10 years' evolution, integrating CPR methodology and scientific rigor. The initial partnership was developed with local sororities (i.e. exist only at one institution) at a small university in 2001, with the goal of replicating Stice and colleagues' (2000) early *TBP* findings. Working with gatekeepers (i.e., individuals who belong to and can access members of a community), we conducted a pilot trial of *TBP* with sorority members who screened for elevated body dissatisfaction. After the trial, in what turned out to be our first step using CPR methodology, we invited former participants to offer feedback and suggestions. Participants reported wanting more of their members to complete the program. Accordingly, we eliminated the screening procedure and investigated whether or not *TBP* yielded positive effects when implemented in a more universal manner. At the time, some researchers were concerned about universal implementation (e.g., Mann et al., 1997). Results from the second trial demonstrated that *TBP* was in fact beneficial regardless of risk status (Becker et al., 2005).

During the next feedback session, community members requested broader

implementation. Of note, we conducted this sorority research without substantial funding or

sufficient expert providers to deliver *TBP*. Thus, we faced our first mismatch between

community needs and available resources. To address this, we used task-shifting, which involves

delivering interventions via non-expert providers (Patel, Chowdhary, Rahman, & Verdeli, 2011).

Specifically, we task-shifted implementation of *TBP* to trained undergraduate peer-leaders. Thus,

CPR methodology (Becker, Stice, Shaw, & Woda, 2009) played a critical role in the evolution of

TBP; several studies subsequently demonstrated *TBP* delivery could be task-shifted to

undergraduate students (Becker et al., 2006; 2008; 2010; Perez et al., 2010).

Following early growth with local sororities, we partnered with a national sorority to

disseminate TBP in North America. In 2008, after three years of relationship building and

piloting, the Tri Delta sorority launched a large dissemination project using the task-shifted,

peer-led version of *TBP*. Early on, however, we determined that task-shifting alone was

insufficient to achieve our collective goals because relying on 1-2 expert trainers limited

program scalability secondary to time constraints and the cost of flying trainers to different

universities. We then adopted a train-the-trainer model (TTT: Zandberg & Wilson, 2012) to

enhance *TBP* scalability. In the TTT model, expert (typically expensive) providers (e.g.,

psychologists with eating disorder expertise), train moderately-expert/expensive providers (e.g.,

university health staff) to train other providers (e.g., students) in the delivery of an evidence-

based intervention. The TTT model not only decreases costs (thus increasing sustainability), but

also decreases travel and scheduling demands and builds capacity within individual

organizations for sustainable delivery (e.g., universities). Thus, in collaboration with our

community partners, we developed a blended task-shifting/TTT approach for implementation of

TBP. In a proof-of-concept study, we demonstrated that use of the blended task-shifting/TTT

approach produced comparable results to the expert-trained, peer-led version of *TBP* on

participant outcomes and protocol adherence (Kilpela et al., 2104).

Regarding lessons learned, one early lesson involved the importance of actively listening

to, and respecting the needs, opinions, and expertise of stakeholders. This allowed us to tailor our

messaging about *TBP* so that it fit with stakeholder values and addressed perceived barriers to

implementation; these, in turn, improved such implementation outcomes as acceptability,

adoption, feasibility and sustainability (Proctor et al., 2011). Second, we learned to identify and

highlight our community partners' strengths (e.g., organization, experience delivering programs

at scale), as opposed to perceived weaknesses and negative stereotypes. Third, we discovered the

powerful role of gatekeepers (e.g., specific sorority members who served as liaisons and

partners) and the importance of recruiting community members onto the

research/implementation team. Last, we learned that operating under real world, sustainable

conditions facilitated creative solutions (e.g., task-shifting/TTT) and raised interesting research

questions. Importantly, the above lessons provided a foundation for all subsequent partnerships.

1.3.1.2 Eating Recovery Center Foundation (ERCF)

The partnership with ERCF points to the value of assertively pursuing novel partnerships

with a wide array of organizations and the importance of managing costs. In 2013, the BPC

launched a pilot partnership with the ERCF, which is the non-profit arm of the residential eating

disorder treatment program, the Eating Recovery Center (ERC). ERCF was primarily interested

in helping to facilitate implementation of TBP at universities. Although some universities

implement *TBP* via clinicians, most use the task-shifting peer-leader approach described below,

which meets a common university goal of creating student leadership opportunities. To optimally

implement in this manner, most campuses partner with the BPC for a one time, 2-day, TTT

training in which a starter cohort of peer-leaders is train along with staff who then sustainably

train subsequent generations of peer-leaders. For this pilot, the ERCF created grants to help

North American universities offset the cost of bringing a trainer to campus to launch the

sustainable TTT/task-shifting peer-leader model. A TBP trainer who worked at ERC originally

proposed this partnership, and subsequently stimulated negotiation with ERCF leadership and

Dr. Becker.

The 2-phase pilot facilitated expansion of *TBP* to 10 new universities over 18 months. At

the end of the pilot, based on mutual satisfaction with the partnership, the BPC and ERCF signed

an exclusive North American agreement which will fund expansion of *TBP* to another 85

universities over 5-year period. The 85 grants will make it possible for universities to receive the

2-day training for as little as $500 out-of-pocket expense.

We learned three lessons from our partnership with ERCF. First, prevention developers

can find new partner organizations with financial resources to support dissemination and

implementation, assuming their missions align. We believe that the ERCF chose to partner with

the BPC for two primary reasons, in addition to their mission to "give back." First, *TBP's* strong

empirical base suggested that the resources ERCF invests will yield positive outcomes; ERCF

clearly wants want their contribution to have a positive impact. Second, those positive outcomes

and *TBP* brand can potentially help name recognition for both the non-profit foundation and the

for-profit company. In essence, *TBP* indirectly increases their brand equity.

With regards to the second lesson, cost matters to many stakeholder communities.

Although some universities can allocate resources for our one-time TTT training, reducing cost

via grants has opened new doors. Third, we can outreach to universities (i.e., cold call/email),

and successfully bring *TBP* to campuses that previously did not plan on running *TBP,* rather than awaiting interest.

1.3.1.3 Arizona State University (ASU)

Although *TBP* has been implemented on over 100 university campuses, ASU represents one of the largest roll outs to date, with hundreds of students completing the program per semester. ASU also stands out regarding significant support from administrators. In this section, we highlight a number of strategies/lessons that we believe played a role in success at ASU, including the importance of marketing and linking TBP to broader institutional goals.

First, consistent with CPR, we aligned the program with the community's mission. For example, prior to approaching ASU constituents, Dr. Perez assessed the impact of the program's target variables (e.g., body dissatisfaction) on ASU students. She then provided digestible statistics to administrators demonstrating how body dissatisfaction impaired academic achievement (e.g., "approximately, 33% of ASU women would rather fail an assignment than give a presentation in front of class due to body image concerns"). Additionally, she repackaged peer facilitator language to align with the university's mission by emphasizing that *TBP* would not only assist in creating a healthy community, but also would infuse the university with female leaders. Tying *TBP* to institutional goals made it more attractive and palatable to administrators.

Another ASU lesson is the importance of marketing. Specifically, prior to implementation, the ASU *TBP* team engaged in a year-long marketing campaign aimed at constituents within ASU. They developed a 5-minute, interactive "pitch" to engage participants and expand discussions about *TBP* at ASU. This pitch was delivered by charismatic individuals and tailored to each sub-community (e.g., undergraduate students, staff at residence halls, student counseling center). Another marketing component included having audiences experience one or

two of the fun interactive *TBP* activities that sell themselves. This gave the audience an idea of what the program is about and simultaneously sold the program.

The final strategy involved adding elements to our research study that assisted administrators. A key struggle on college campuses for any program is getting students to participate. We are employing and testing various cost-effective incentive strategies, and we share results with university officials.

In summary, ASU lessons include the value of an organized marketing plan. ASU also demonstrates how connecting *TBP* to larger university concerns, values and goals increased stakeholder buy-in. This extends to designing research studies that not only address questions relevant to *TBP* but also other university programs.

1.3.2   Foundations

1.3.2.1 Dove, WAGGGS and the *Free Being Me*

In 2012, the Dove Self Esteem Project (DSEP) embarked upon an update of their educational programs with the aim of utilizing best practices for improving body image. Dove also sought partnerships with key organizations to maximize global scalability and impact. Ultimately, they decided to fund and implement a global body image program for young girls with the World Association of Girl Guides and Girl Scouts (WAGGGS), which is the world's largest youth organization for girls. Our partnership with Dove and WAGGGS showcases the value of a) bringing together very different constituencies towards a common goal and b) respecting the different strengths each constituency brings to the table.

In consultation with Dr. Diedrichs, who served on the DSEP advisory board and had extensive *TBP* experience, WAGGGS and Dove chose *TBP* as the foundation for their new program, *Free Being Me* (http://www.free-being-me.com). This decision was based on a) *TBP's*

extensive evidence base, b) *TBP's* focus on providing girls with opportunities to speak against

sociocultural pressures, demonstrate leadership, and engage in community activism, which are

consistent with WAGGGS' values, and c) past evidence of successful *TBP* partnerships using

CPR. Accordingly, members of the DSEP, WAGGGS, and Dr. Diedrichs worked closely with

Drs. Stice and Becker using an iterative process to adapt *TBP* to meet the needs of WAGGGS'

non-formal education approach and global multicultural population. With the assistance of Drs.

Diedrichs and Becker, WAGGGS subsequently created their own TTT model, with global

trainers delivering national trainings around the world, after which trainees cascaded training

down to local organizations.

Enthusiasm for *Free Being Me* from WAGGGS' member organizations has been

enormous. Since November 2013, 120 countries across six continents have adopted *Free Being

Me*, which is now available in 16 languages. WAGGGS reports that over two million girls and

boys have received the program in some form. WAGGGS also recently partnered with Drs.

Diedrichs and Stice to conduct global dissemination and implementation research to understand

the uptake and effectiveness of *Free Being Me*, creating the first global body image

dissemination/implementation study.

Regarding lessons learned, this partnership taught us that global dissemination of

evidence-based body image interventions will necessitate different constituencies learning to

work together flexibly and creatively; in this case a multinational brand with a social mission, a

global youth organization, and body image researchers. We also learned that it pays to recognize

and respect the diversity of strengths that different members of *TBP* community have developed

(e.g., Stice: manual format and lessons from early testing, Becker: TTT model and CPR,

Diedrichs: partnership expertise/trust with Dove and WAGGGS) as well as the strengths of our

partners (e.g., WAGGGS: non-formal education; Dove: global reach and resources), and to work together to maximize what we can collectively accomplish.

1.3.2.2 National Eating Disorders Association (NEDA)

The BPC and NEDA partnership once again highlights the importance of cost-effective, scalable models as well as the utility in partnering with grassroots organizations. We began this partnership in 2012 with discussions about the adaptability of the TTT model to NEDA's infrastructure and possibilities for financial support. NEDA expressed interest in the program because it fit with NEDA's longstanding goal of advancing prevention; this goal previously had been sidelined because of the lack of evidence-based programs. Thus, NEDA interest in *TBP* was rooted in a) the evidence base and b) their sense *TBP* it fit with other initiatives (e.g., NEDA's positive web-based community proud2bme.org) and would be a good investment of resources. Together, we submitted several grants and ultimately were funded initially to bring *TBP* to underserved high school girls in New York City (NYC).

To establish NEDA's base with *TBP*, we conducted three 2-day TTT sessions to train both layperson group facilitators and trainers of group facilitators. We also trained two NEDA staff as "master" trainers in TTT training for future program expansion. To date, NEDA has delivered *TBP* to high school girls in NYC per the original charter of the grant. They also have engaged in outreach to community-based organizations and will expand delivery of *TBP* in NYC. Additionally, NEDA is offering a full day of facilitator training as a pre-conference workshop for the annual NEDA conference. Demand for training was so high that they added an additional training session to their 2015 annual meeting.

Our partnership with NEDA again highlights the importance of the TTT model. Specifically, being self-sufficient and able to scale-up delivery sustainably were essential to NEDA. Additionally, we observed the benefits of connecting to an organization's existing values and programming. For instance, the ability to link *TBP's* messages directly to Proud2BMe allowed two seemingly independent endeavors to work symbiotically. Lastly, this partnership highlights the advantages of building relationships with grass-roots organizations.

1.3.2.3 Comenzar de Nuevo (CdeN)

The BPC partnership with CdeN, a Mexico-based not-for-profit foundation for eating disorders treatment, demonstrates the importance of: global professional organizations, integration of business models, aggressive marketing, and using the *TBP* to advance broader research agendas. This partnership began after a *TBP* workshop conducted at the Academy of Eating Disorders (AED) International Conference for Eating Disorders. Dr. Trujillo and a colleague approached Dr. Becker about forming a partnership; importantly all three individuals were long standing members of AED and had previously networked through the organization, which facilitated partnership development. CdeN's interest in *TBP* was rooted in its utility for community outreach and giving back as well as the evidence-base, which made them feel confident that resources would be well spent.

A key aspect to the success of this partnership has been the development of a sustainable business model. Although other partnerships have sought to reach relatively large populations of individuals, CdeN is the first non-profit to set a goal of reaching hundreds of thousands in multiple countries with *TBP* despite not currently having the infrastructure to do so (e.g., Dove/WAGGGS partnership is supported by generous funding from a major corporation and built on WAGGGS existing infrastructure). To accomplish this, CdeN recruited two business

executives from Mexico to create a business model with a 3-year plan towards self-sustainability. The development of the business plan required extensive collaboration between the business executives, the BPC, and CdeN. The BPC had to re-analyze data collected during previous trials and implementation efforts in novel ways, share financial data with the business executives to check assumptions, and provide expertise about implementation.

After developing the business plan, CdeN hired a marketing agency and started a marketing plan targeting Mexico and Latin America that included video creation and a social media campaign. Marketing also included adapting the concept to Latin culture by creating a Spanish name for *TBP*, translating the BPC webpage into a Spanish webpage www.hagamosbip.net. Although CdeN's business plan starts locally with later expansions to the rest of Mexico and all of Latin America, CdeN began immediate marketing beyond the local region to generate interest. Relying again on relationships often built through the Hispano Latino American Chapter of the AED, CdeN organized a network of colleagues to promote the program in other countries. Lastly, CdeN created an "adopt a school" program linking foundations and companies with public schools to help bring *TBP* to those schools.

As with other partnerships, we again have seen the importance of linking *TBP* to other initiatives that resonate with our partners. For instance, the eating disorders field currently has limited research on what aspects of prevention programs are effective across cultures Thus, as part of our partnership with CdeN, we are collecting both quantitative and qualitative data on Mexican and Latino participants' experiences with the hope of answering key questions for the globalization of prevention. We also plan to use the program as a platform to facilitate other research projects that are of interest to Latin American partners.

1.4   Challenges in Partnering with Stakeholder Communities

Although we believe that advancing universal prevention requires developing partnerships with an array of stakeholder communities, we would be remiss if we did not identify some of the challenges researchers might encounter in such work. First, developing such partnerships is very time consuming and often researchers' time is not compensated during the early stages partnership of development. Second, even some successful partnerships break down over time. For instance, secondary to staffing changes, which can happen with any stakeholder community, Tri Delta decided in 2012 that it only wanted to focus on programming for its members, a decision that countered the original agreement between Dr. Becker and Tri Delta; this change in Tri Delta's goals ultimately led to the end of that partnership. Third, large scale dissemination requires some degree of infrastructure (e.g., people to respond to questions, a business plan, development of contracts, marketing). On the one hand, it can be really beneficial to allow stakeholder partners to take the lead in this area. On the other hand, one risks losing all infrastructure if the partnership dissolves; indeed this is happened with Tri Delta. For this reason, we now adopt a middle road approach, where we have created some of our own infrastructure via the Body Project Collaborative, which is then augmented by stakeholder partners for certain geographical regions or special populations. Maintaining infrastructure, however, is also time consuming and often done on at least a partial volunteer basis.

1.5   Conclusion

During the last decade and a half, members of the BPC have been fortunate to work with a diverse group of stakeholder communities who valued the strong evidence-based for *TBP*. We are sure that we have learned as much, if not more, from our partners than they learned from us. It is beyond the scope of this paper to detail all of the ways in which our partners have helped us improve our implementation outcomes; yet one overarching lesson is that many stakeholder

communities have an array of skills, resources, experience and knowledge that directly addresses many of the barriers that often prevent researchers from achieving successful implementation. To benefit, however, researchers need to take the time to form relationships, listen and learn. Our primary aim in writing this paper was to offer an array of lessons learned so that other intervention developers might benefit from our experiences. We fully believe that each successful partnership has laid vital groundwork for subsequent partnerships and hope that future researchers can use the case study of *TBP* to advance dissemination and implementation of other programs.

References

Becker, C. B., Smith, L. M., Ciao, A. C. (2005). Reducing eating disorder risk factors in sorority members: A randomized trial. *Behavior Therapy, 36*(3), 245-253.

Becker, C. B., Smith, L., M., & Ciao, A. C. (2006). Peer-facilitated eating disorder prevention: A randomized effectiveness trial of cognitive dissonance and media advocacy. *Journal of Counseling Psychology, 53*(4), 550-555.

Becker, C. B., Bull, S., Schaumberg, K., Cauble, A., & Franco, A. (2008). Effectiveness of peer-facilitated eating disorders prevention: A replication trial. *Journal of Consulting and Clinical Psychology, 76*(2), 347-354.

Becker, C. B., Stice, E., Shaw, H., & Woda, S. (2009). Use of empirically supported interventions for psychopathology: Can the participatory approach move us beyond the research-to-practice gap?. *Behaviour Research and Therapy, 47*(4), 265-274.

Becker, C. B., Wilson, C., Williams, A., Kelly, M., McDaniel, L., & Elmquist, J. (2010). Peer-facilitated cognitive dissonance versus healthy weight eating disorders prevention: A randomized comparison. *Body Image, 7*, 280-288.

Brown, T. A., & Keel, P. K. (2015). A Randomized Controlled Trial of a Peer Co-led Dissonance-Based Eating Disorder Prevention Program for Gay Men. *Behaviour Research and Therapy, 74*, 1-10.

Green, M., Scott, N., Diyankova, L., Gasser, C., & Pederson, E. (2005). Eating disorder prevention: An experiemental comparison of high level dissonance, low level dissonance, and no-treatment control. *Eating Disorder, 13,* 157-170.

Halliwell, E., & Diedrichs, P. C. (2014). Testing a dissonance body image intervention among young girls. *Health Psychology, 33*(2), 201.

Israel, B., Eng, E., Shculz, A., & Parker, E. (2005). Introduction to methods in community-based participatory research for health. In Israel, B. A., Eng, E., Shulz, A. J., & Parker, E. A. (Eds.),*Methods in community-based participatory research for health* (pp. 3-26). San Francisco: Jossey-Bass.

Jankowski, G. S., Diedrichs, P. C., Fawkner, H., Gough, B., & Halliwell, E. A pilot controlled trial of a cognitive dissonance body image intervention for men. Manuscript submitted for publication. *Behaviour Research and Therapy*.

Kazdin, A. E., & Blase, S. L. (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives on Psychological Science, 6*(1), 21-37.

Kilpela, L. S., Hill, K., Kelly, M. C., Elmquist, J., Ottoson, P., Keith, D., Hildebrandt, T., & Becker, C. B. (2014). Reducing eating disorder risk factors: A controlled investigation of blended task-shifting/train-the-trainer approach to dissemination and implementation. *Behaviour Research and Therapy, 63,* 70-82.

Kilpela, L. S., Blomquist, K., Verzijl, C., Wilfred, S., Beyl, R., Becker, C. B. (2015). Body project 4 all: What happens when men are included in a historically female-only body image intervention? Manuscript submitted for publication.

Mann, T., Nolen-Hoeksema, S. Huang, K., Burgard, D., Wright, A., & Hanson, K. (1997). Are two interventions worse than none? Joint primary and secondary prevention of eating disorders in college females. *Health Psychology, 16*(3), 215- 225.

Matusek, J. A., Wendt, S. J., & Wiseman, C. V. (2004). Dissonance thin-ideal and didactic healthy behavior eating disorder prevention programs: Results from a controlled trial. *International Journal of Eating Disorders, 36*(4), 376-388.

Mitchell, K. S., Mazzeo, S. E., Rausch, S. M., & Cooke, K. L. (2007). Innovative interventions

for disordered eating: Evaluating dissonance-based and yoga interventions. *International

Journal of Eating Disorders, 40*(2), 120-128.

Mrazek, P. J., & Haggerty, R. J. (Eds.). (1994). *Reducing Risks for Mental Disorders: Frontiers

for Preventive Intervention Research.* National Academies Press.

Patel, V., Chowdhary, N., Rahman, A., & Verdeli, H. (2011). Improving access to psychological

treatments: Lessons from developing countries. *Behaviour Research and Therapy, 49*(9),

523-528.

Perez, M., Becker, C. B., & Ramirez, A. (2010). Transportability of an empirically supported

dissonance-based prevention program for eating disorders. *Body Image, 7*(3), 179-186.

Proctor, E., Silmere, H., Raghavan, R., Hovmand, P., Aarons, G., Bunger, A., Griffey, R., &

Hensley, M. (2011). Outcomes for implementation research: Conceptual distinctions,

measurement challenges, and research agenda. *Administration and Policy in Mental

Health Services Research, 38*, 65-76.

Seidel, A., Presnell, K., & Rosenfield, D. (2009). Mediators in the dissonance eating disorder

prevention program. *Behaviour Research and Therapy, 47*(8), 645-653.

Shoultz, J., Oneha, M. F., Magnussen, L., Hla, M. M., Brees-Saunders, Z., Cruz, M. D., &

Douglas, M. (2006). Finding solutions to challenges faced in community-based

participatory research between academic and community organizations. *Journal of

Interprofessional Care, 20*(2), 133-144.

Stice, E., Mazotti, L., Weibel, D., & Agras, W. S. (2000). Dissonance prevention program

decreases thin-ideal internalization, body dissatisfaction, dieting, negative affect, and

bulimic symptoms: A preliminary experiment. *International Journal of Eating Disorders, 27*, 206-217.

Stice, E., Trost, A., Chase, A. (2003). Healthy weight control and dissonance-based eating disorder prevention programs: Results from a controlled trial. *International Journal of Eating Disorders, 33,* 10-21.

Stice, E., Shaw, H., Burton, E., & Wade, E. (2006). Dissonance and healthy weight eating disorder prevention programs: A randomized efficacy trial. *Journal of Consulting and Clinical Psychology, 74*(2), 263-275.

Stice, E., Shaw, H., & Marti, C. N. (2007). A meta-analytic review of eating disorder prevention programs: Encouraging findings. *Annual Review of Clinical Psychology, 3*, 207-231.

Stice, E., Marti, C. N., Spoor, S., Presnell, K., & Shaw, H. (2008). Dissonance and healthy weight eating disorder prevention programs: Long-term effects from a randomized efficacy trial. *Journal of Consulting and Clinical Psychology, 76*(2), 329-340.

Stice, E., Rohde, P., Shaw, H., & Gau, J. (2011). An effectiveness trial of a selected dissonance-based eating disorder prevention program for female high school students: Long-term effects. *Journal of Consulting and Clinical Psychology, 79*(4), 500-508.

Stice, E., Becker, C. B., & Yokum, S. (2013). Eating disorder prevention: Current evidence-base and future directions. *International Journal of Eating Disorders, 46*(5), 478-485.

Stice, E., Rohde, P., Butryn, M. L., Shaw, H., & Marti, C. N. (2015). Effectiveness trial of a selective dissonance-based eating disorder prevention program with female collect students: Effects at 2-and 3-year follow-up. *Behaviour Research and Therapy, 71,* 20-26.

Zanberg, L. J., & Wilson, G. T. (2012). Train-the-trainer: Implementation of cognitive

behavioural guided self-help for recurrent binge eating in a naturalistic setting. *European*

Eating Disorders Review, 21(3), 230-237.